Immigrant Healthcare Access in Clarkston, GA: Mismatches in Capacity and Perception

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Abstract

Migrant and refugee healthcare is an under-represented area of the medical and community development literature, making it difficult to understand barriers to healthcare access within these populations. Without an adequate flow of information between community service organizations, healthcare providers, and individual healthcare recipients, substantial gaps may develop between needs, capacity, and access. Here, we present qualitative data from interviews conducted in Clarkston, GA, a major refugee resettlement site in the United States, which demonstrate mismatches between the availability of healthcare and perceived health needs. In terms of healthcare capacity, participants indicated that services which they need—such as employer-funded health insurance, specialist care, and high-quality primary care—were frequently unavailable. In terms of health perceptions, participants frequently lacked knowledge about important components of the healthcare system—such as the purpose and cost of health insurance, the function of the private health insurance market for small businesses, or the purpose of preventative care. Developing an understanding of these discrepancies, and the information gaps that create them, is an essential step toward effectively targeting high-quality healthcare services to migrant populations.

Introduction: Clarkston Healthcare Basics

Background

Clarkston, GA is a small incorporated city in the eastern suburbs of Atlanta, located just outside the I-285 perimeter, east of Decatur and south of Tucker. Clarkston was founded in the 1840s as a rail siding on the route from Athens to Atlanta and was chartered under the name of Clarkston in 1882. In the 1980s, the development of numerous affordable housing complexes in the Clarkston area caused voluntary organizations to begin resettling refugees in the area. Clarkston has been the first American home for over 40,000 refugees (City of Clarkston, n.d.).

Residents of Clarkston are 10.5% white, with the three largest ethnicities being Black/African American (55.0%), Asian (29.6%), and Native Hawaiian/Pacific Islander (28.1%) (United States Census Bureau, 2013-2017). Within the Clarkston ZIP code, the most commonly reported non-U.S. first ancestries are Ethiopian, Somali, and Liberian (30021 Zip Code, n.d.). Within the 5.6 square miles of greater Clarkston, 33% of the population live below the federal poverty line, 23% are linguistically isolated, and 32% have less than a high school education (United States Environmental Protection Agency, 2018). Clarkston's crime rate for both violent and property crime is higher than that of surrounding counties, as well as the Georgia and national averages (Clarkston, Georgia Crime, 2019). Interestingly, however, Clarkston's unemployment rate is low compared to other areas with similar levels of poverty (Shaer, 2018), and the city of Clarkston is far more likely than DeKalb County to have family households with children rather than non-family households (City of Clarkston). Clarkston's unemployment currently matches the national average at 3.9%, and the city has higher past and projected job growth than the national average (Clarkston, Georgia Jobs, 2019).

Compared to the United States as a whole, Clarkston's immediate area ranks in the 88th percentile for minority population, the 90th percentile for low-income population, the 94th percentile for linguistic isolation, and the 90th percentile for residents with less than a high school education (United States Environmental Protection Agency, 2018). While it is possible under the Affordable Care Act for refugees to purchase extended coverage on a marketplace, 32.7% of Clarkston's population remains uninsured (United States Census Bureau, 2013-2017). Additionally, Clarkston's environmental health risks are higher than most of the country, with

the city falling in the 90th-95th percentile for cancer risk from air toxins, and the 80th-90th percentile for respiratory hazards (United States Environmental Protection Agency, 2018).

Migrant Healthcare Literature

Health systems which serve refugee populations must work in an environment with an unusual variety of patient histories, genetic risk factors, complex psychological traumas, linguistic and cultural differences, lack of voting rights for the non-citizen population, economic inequality, complex public health challenges, communication issues between governmental, nonprofit, citizen, and immigrant actors, and other issues (Nicholson, 2018). Any of these factors may restrict access to care. Additionally, resettled refugees' temporary medical insurance, known as Refugee Medical Assistance (RMA) runs out eight months after arrival in the United States ("Health Insurance"). The academic literature on healthcare for refugee and immigrant populations is very scattered—a 2014 research methods handbook noted that, "Existing books on global and public health generally have very little or no discussion of the association between human migration and health" (Rodriguez-Lainz, Xochitl, & Schenker, 2014).

A recent Canadian literature review found several trends in barriers to access for immigrants and refugees. Among the studies reviewed, the most common barriers to access were "language barriers, barriers to information, and cultural differences" (Kalich, Heinemann, & Ghahari, 2016). A smaller study in rural Maryland echoed these problems, but added challenges which are somewhat unique to the American healthcare system— "lack of health insurance coverage" and "high health expenditures" (Sangaramoorthy & Guevara, 2017).

The healthcare treatment of refugees is inseparably linked to cultural and personal sensitivity. The best outcomes are seen when medical personnel are prepared to engage with patients in a way that actively adjusts to the unique needs of refugee populations. A bulletin from Australia lists a few of the most important needs—culture-related "expectations for care" including beliefs about health, "individual context and experiences, including pre-migration experiences," and language differences which may include issues with health literacy (Abbasova, 2017). Addressing these issues can lead toward "trust and collaboration-based relationships" between clinic staff and refugee patients (Abbasova, 2017). Unfortunately, the literature indicates that there are serious unsolved issues related to the cultural literacy of many medical professionals, which negatively impact access to care (Kalich et al., 2016). The relevant literature builds toward a consensus that education and sensitivity among health workers are the most important steps toward effective medical care for refugees and migrants.

Healthcare Access

Clarkston's low-income population is currently served by one Federally Qualified Health Center (FQHC), one FQHC-applicant clinic, two free clinics, numerous fee-for-service providers, and one nearby hospital. The nearest FQHC is Oakhurst Medical Centers in Stone Mountain, but its penetration of the total population in the Clarkston Zip Code Tabulation Area is quite low at 8.2%, with a similarly concerning 11.6% penetration of the low-income population (UDS Mapper, n.d.). Located more centrally to Clarkston, Ethnē Health, a new clinic which opened in October of 2018, also operates on the FQHC model—including sliding-scale fee schedules for uninsured patients—and has applied for official FQHC status. Ethnē currently operates four half-days per week, with plans to expand hours in the near future.

Within Clarkston city limits, other low-cost primary care options for low-income and uninsured patients are two free clinics, the Clarkston Community Health Center and the Grace Village Medical Clinic. Both are limited in their service capacity—the Community Health

Center operates three half-days every week with significant reliance on student trainee staff from Emory University (Clarkston Community Health Center, n.d). Grace Village Clinic operates two days per month with volunteer staff from the Christian Medical and Dental Association (Grace Village Medical Clinic, 2018). Uninsured patients who do not choose to visit Oakhurst, Ethnē, CCHC, or Grace may choose to pay out of pocket to visit another physician, or may wait to seek care until they are sick enough to require a hospital visit.

Since more than 70% of the population in Clarkston is either uninsured or on Medicaid/Medicare, and since no full-service clinics seem to reach most of these individuals, many sick individuals are likely either staying home or going to Emory Decatur Hospital for emergency care. This conclusion is borne out in Georgia Online Analytical Statistical Information System (OASIS) data, which indicates that Medicaid recipients in the Clarkston ZIP code are more than 13 times more likely to access a hospital ER than individuals with private insurance. OASIS also indicates that child mortality and early mortality in Clarkston are both approximately twice as high as the U.S. national average. Of every 1,000 babies born in Clarkston, 10.5 die before they reach one year of age (The Need in Numbers, 2018).

Materials and Methods

Study participants were identified through various techniques: snowball sampling, cold calls, and through community connections from staff at Ethnē Health. In all, 31 interviews were conducted. Participants included 21 employees of local organizations, along with 10 organization leaders/managers from 10 community organizations. All of the organizations represented in the sample were either nonprofits (including both religious and nonreligious organizations) or social benefit corporations. Note that the sampling in this study was not designed to generate statistically significant descriptions of the general population.

Two primary research tools were employed: a semi-structured interview form, which was used in conversations with community members, and an unstructured interview guide, which was used in conversations with local business owners and organization leaders. These guides were similar in content—all participants were asked to reflect on their own health behaviors and the health behaviors of people in their community, while business leaders were asked additional questions about their organization's approach to providing health insurance to employees.

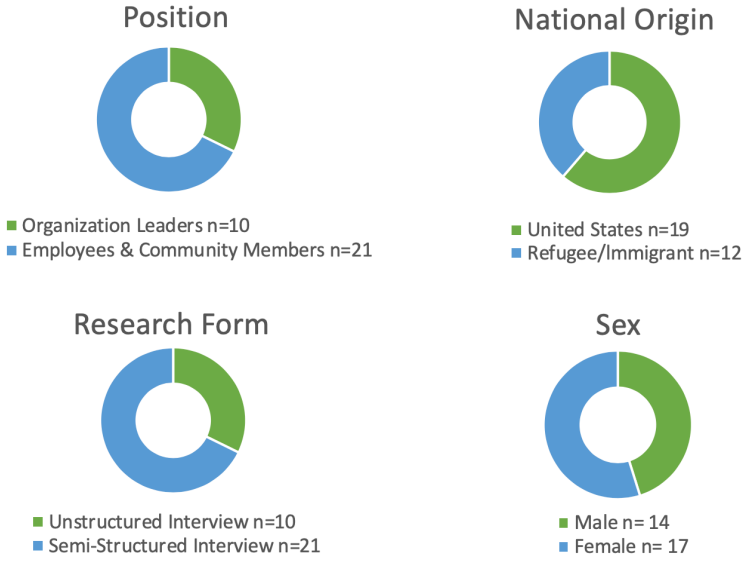

Figure 1. Descriptive statistics for interview participants.

Results

Capacity Mismatches

We found that desired medical services were often unavailable to participants due to issues of cost, time, distance, and quality. This category of issues includes problems which cannot be addressed by individuals on their own, requiring action from employers or healthcare service providers.

1. Access to Health Insurance

> *"People are afraid because they don't have enough money to see the doctors. They ask, 'How can I go if I don't have insurance?' Do you see? They pull insurance in the front. They see insurance first. Then they see other things." – Malachi,[1] a Central African refugee*

Many people in Clarkston, especially refugees, lack insurance entirely. Among those who have some type of healthcare coverage, many are underinsured, having only catastrophic coverage that does not enable them to visit a physician for preventative care. Zeyar, a refugee from Southeast Asia, expressed that most refugees do not choose to purchase insurance after their RMA Medicaid plan ends: "A lot of people don't have insurance. After Medicaid, they just don't even think about getting insurance… Some people, they don't even have money for rent. Insurance is the last thing they think of. First, food on the table. And then rent." Apartment rent in Clarkston can be prohibitively expensive. When asked about refugees' healthcare expenditures, Qasim, a North African immigrant who is a leader at a nonprofit, said that, "Remember we are asking these refugees to go outside where they live an hour and a half for a chicken factory. What do they make? $9 an hour. But the rent is $900, maybe $2,000 a month. So almost 90% of their salary goes to rent."

As mentioned by Qasim, refugees sometimes attempt to address their need for insurance by working at one of the large chicken processing companies in the area, such as Tyson Foods. Meredith, a nonprofit worker, said that, "A lot of refugees that I've noticed choose to work in a chicken factory because chicken factories have competitive benefits packages. So a lot of people choose the employment based on the benefits. Even over the pay." But jobs at chicken factories and similar large corporations (Fresh Express, Home Goods, and Marshall's were mentioned several times) come with their own problems. For one thing, it is typical for only the family member who works in the factory—generally a male head of household—to be covered by insurance, while his children are covered by Medicaid and his wife goes without insurance. This can cause a gender gap in access to care. Additionally, the work at chicken factories is difficult and degrading. Malachi expressed a common perception of chicken plant jobs as unhealthy, saying that "those people that work for chicken companies, they have a lot of fever. Most of them, they are sick a lot, because it's too cold. And [chicken factories] cause many problems--they cause high blood pressure, they cause sickness in the bones, people have diseases because they touch the chickens. They can be affected on the eyes."

Furthermore, the insurance available from working in factory and warehousing jobs is not necessarily of good quality. Qasim explained that, "Ninety percent of the health insurance available at work... They have high deductibles. Very high deductibles. They have like two thousand, three thousand, four thousand [dollars] you have to pay yourself. These people cannot go through a health savings plan. They just can't, they don't have extra money. They have bills. A

[1] All names and identifying details have been changed to protect participants' privacy. All participants signed an informed consent and agreed to have their statements reported anonymously.

lot of bills to pay. Car insurance in this area is very high. Water bills in this area is very high. Electricity in this area is very high. Apartments. You have seen it. They're not sealed well-- they're averaging $500 a month of utilities. They're averaging car insurance over $250 a month, compared to where I live in Lawrenceville. You know, it's all of that combined right? All of this compounds. You pay more. Your credit is bad. You pay more."

Most participants in the sample worked for small businesses and nonprofits, rather than the larger warehousing and factory corporations. Many of these small businesses struggle to find affordable healthcare solutions for their employees, which may lead to employee dissatisfaction, and may negatively impact access to care. One nonprofit leader expressed the problem of finding insurance by saying, "For us it's cost and and value. Everything we spend, we have to raise. Our payroll costs, all in, are easily 66% of our total cost. And so, and frankly, our compensation is not... Just our flat-out pay is low. So you take a payroll and you say, well, adding health insurance would raise your payroll costs 5%. If I just put that down to the full-time employees, you're still talking close to $50,000 a year and that just doesn't... You don't enter a budget cycle, saying, oh yeah, we'll go raise that." Despite these issues, numerous small business employees expressed dissatisfaction with their employer's insurance solutions. Fiona, a young nonprofit employee, expressed that, "Sometimes with nonprofits, there's a disconnect in how we treat our clients and how we treat each other. It doesn't make a lot of sense to me that we're all working our asses off, working way more than nine to five, to serve the community. But we're not making sure that people within our own family are taken care of. I know that there are some folks who have opted out of insurance and it's just not an option for them. And I know that that it has affected our lives for sure. I think it affects morale when you don't feel like you're being valued."

2.a. Availability of Specialist Care: Dental Care

"Dentistry is a huge gap. I've experienced that. Our Medi-Share doesn't cover dentistry, so my wife and I are trying to save up for a couple of years to be able to go get a cleaning and a check-up. That feels like a real luxury to us." – Kevin, a ministry leader

Frequently, participants mentioned that while they might be able to access primary care if they needed it, they had no way to reliably find a dentist, even for serious dental problems. Brenda, a nonprofit employee with several children, told a story about trying to get one of her children's wisdom teeth removed: "Our kids have dental insurance and eye insurance, and we don't. Access to a dentist is a pain in the rear. My oldest has phased out of pediatric dentistry, and so trying to find an adult dentist that will take PeachCare for kids is... He was having to have oral surgery, and so the place that we ended up was kind of janky looking. It's kind of like this run-down house where he did the surgery, he's like 'Yeah that room right there.' And I was like, 'Oh please Lord let that room be clean.' But, you know it's either that, or he doesn't get them out. We can't afford it." Hamid, a recently resettled refugee from the Middle East, expressed a similar story:

H: One time I went to the dentist, because I was having a problem with my teeth, and he just told me a lot of money.
WP: So you decided not to do it?
H: Yeah, because I don't have that money. And I don't have insurance.

Amayah, a Syrian refugee, characterized dentistry as being the hardest type of medical service to access: "Honestly, primary care is not the problem for us. The problem is dental, the dental, which is for me every time thousands of dollars."

2.b. Availability of Specialist Care: Women's Health

"Our participants are all women. Most of them do not have coverage. Sometimes their husbands do and their children do, but the women do not. Often they are married to men who work and can get [insurance]. And then the children can get PeachCare so it's the women who are often left out." – Karen, a nonprofit worker

A second difficulty in accessing specialist care was apparent around the issue of women's health. According to the accounts of many community members, adult refugee women are the least likely members of the population to have insurance, and to seek care for themselves. This problem takes two distinct routes: access to primary care, and access to OB/GYN care.

Women may be less likely to go to a doctor at all because of a lack of insurance. Additionally, because many women are responsible for childcare in their households, they may feel unable to visit their own doctor due to the need to care for their children. Karen, quoted above, also said that, "For accessibility for a woman with three young children, you've got to get on a bus to go, you've got to load your stroller onto that bus and get them there, once you get there, you might have to wait in a waiting room with three hungry children who don't have anything to do. Because you can't afford childcare. So you know, these are all... I know I've personally not gone to appointments because of the hassle of getting children there, I've not done that myself, and I could pay for a babysitter, and I have my own transportation." Tamon, a refugee dad from Southeast Asia who has worked his way up into management in a small business, described the problem of taking children to a free clinic with long wait times: "The waiting time and the crowd, I have heard from so many people, I can give an example of Oakhurst on Memorial Drive. When you go there for pediatrician doctor and you have a breastfeeding baby and you wait like two hours, that's crazy. They're giving you an appointment, but you go to see the doctor after two, three hours from the appointment time. Something is wrong with that…. I drive, I can drive 30 minutes [to see a pediatrician]. Thirty minutes, my kids can enjoy inside the car. We can talk, we can listen to music. But I cannot ask them to not move inside the clinic. Because the kids, they run away. They play, it's hard to handle them waiting for two hours, but 30 minutes inside the car you can handle them. So if I drive 30 minutes, I don't care, but I can't wait two hours for, for the pediatrician doctor to see my kid."

Several female participants also expressed that gynecological services were highly important to them, and that they the availability of gynecologists in Clarkston is inadequate. Fiona said that instead of a primary care physician, she tends to go to her gynecologist instead: "The person I see most frequently, which is not frequently at all, is my gynecologist. That's who I go to about most things. I don't really have a PCP." Sarah, a young caseworker at a local nonprofit, said that she believed making space for women is important for improving their access to care—"Women would be more likely to pursue care with a gynecologist that they trusted than another doctor. I feel like regular feminine checkups are something most women in this area don't have." Forming access to a personalized space for women—such as a gynecologist's office—may be an important step toward encouraging women to look out for their own health. One young refugee mother said that, "I think it's one of those things that I have to learn, because I used to forget myself...you know, my lifestyle. I do care for my kids, not for myself."

3. Quality of Physicians

"Honestly, I'm not happy with the clinic that my child goes to. But I just haven't had time to find another place. They're unorganized. Each time they have different, a different student or different doctor.

I don't know what…sometimes they conflict with their opinions on his health. So it's stressful." – Amayah, a Syrian refugee

Aside from problems with the availability of physicians, there are also issues with community trust of healthcare providers. As indicated in the quote above, one problem arises from the use of student trainee staff at both of Clarkston's free clinics, CCHC and Grace Village. Amayah expressed frustration with the professionalism of student doctors: "So many people, sometimes they get the wrong information from them because [the doctors] are students, and they are cheap, and because they don't have good experience. Sometimes if you Google this stuff, and you ask an expert in this field, you may get a better solution then if you go into [the clinic]." There are also problems related to wait times and cleanliness. Tamon, the Southeast Asian refugee who was quoted above about finding a pediatrician for his children also reflected that, "I did try [to find a doctor in Clarkston], but at some places it's too crowded. The waiting time is too long. Time is-- people say-- gold money. Time is very precious. And also the place has to be very neat. Like some places they don't think about the sanitation a lot and still they name it 'Health.' 'Healthcare.' Once you go there, you'll see the places. Everything is too dirty and not good. People don't feel comfortable." Occasionally complaints arose about private practitioners as well. Three participants (all working for the same nonprofit organization) mentioned a local OB/GYN physician as being of poor quality: "There is one particular practice that I would just say, I think they wish he would just retire or die. Because he's not, you know, this is a physician that apparently is not kind to patients, doesn't follow the rules, you know, et cetera. But he takes Medicaid."

Perception Mismatches

Problems in healthcare access among participants did not always arise from poor availability of services, or from poor quality of services. Barriers also arose from poor availability of correct information about services, and from individual health decisions. Generally, these are issues which can be addressed at the level of community health promotion, refugee casework, or individual decision-making.

1. Knowledge of the Health System

"The worst year in my life, even worse than what happened in Afghanistan, the war and everything, the worst year was my first year here because I don't know what's going on here. For example, if I took the shuttle, two buses, will sometimes take me three hours because I don't know how to say I want to go to this place or that. They didn't teach us. What hurts me, that when I worked as an interpreter the last two years, I discovered that our health insurance that the government provided us, they provide non-emergency transportation. Which is amazing! ….I only discovered it when I'm volunteer to people. And I used to walk in the hot or the cold, I used to walk sometimes 45 minutes because every shuttle costs $2.50, which is not cheap for refugees, for somebody who has not $10 in his pocket. So I literally took from my time maybe four or five hours sometimes. To get to my doctor. That [non-emergency transportation] is something that I just discovered. So I don't know why no one told me." –Nadira, an Afghani refugee

Among the three clinics in Clarkston intending to serve the refugee population with free or low-cost services—CCHC, Grace Village, and Ethnē Health—Ethnē's internal estimates indicate that perhaps less than 1/3 of the total primary healthcare need is being met by all of these clinics running at full capacity. Nonetheless, Ethnē did not experience a rapid influx of new

patients when it first opened in October of 2018—instead, it has experienced a steady month-over-month growth in new patient visits, often through word of mouth referrals. The existence of significant health needs in the Clarkston area, combined with this relatively sedated growth at a new clinic, suggests that community members may not be well informed about the availability of resources in their area.

This suspicion is borne out in our qualitative interview data. Several refugee participants, such as Nadira above, mused about why they did not find out about important services until several years after their arrival. Several also expressed ongoing problems with understanding certain aspects of how to access healthcare, noting an inability to find assistance. Discussing how people decide to get insurance at chicken plant jobs, a young Middle Eastern refugee noted, "Most of the people there, they don't speak English, so they just accept it and sign it. Maybe they're wrong because of misunderstanding sometimes. They don't know what kind of insurance they've signed." Oftentimes, the minutiae involved in obtaining healthcare can be difficult to decipher. Cara, an Ethiopian refugee, expressed that, "I don't know for the people who were born here and raised here... but a person like me, refugees we, we don't have... You have to understand from the beginning. Before you come to understand how it works, the system, you need to know a lot of small details to achieve your goals. Like, what is income? My family size, what does that mean? If I just lost my job, what's going on? If I don't pay my insurance, what comes next? Do they sue me? Do we have to see a lawyer when we sign a paper? Yeah. We think it is hard."

Nonprofit employees and caseworkers also frequently wondered about what resources they might not be aware of, and why community members are not better connected to resources. Kevin, the leader of a local ministry, expressed, "I have a feeling, that [Ethnē's] work, and also Grace Village, if people knew about it and were able to go the first time, that would fill a lot of the gaps that there are." Mariah, an African American caseworker, explained the problems involved in keeping track of community resources:

M: I do not think people know where the clinics are. It's going to take caseworkers, is going to take leasing offices, going to take leaders in the community that have full access to people, especially in English as a second language populations, to know where to go.

WP: Is that up to, you know, the voluntary agencies? Is it up to you?

M: All of us. We all need to have a recurring, updated live document that has a list of all the resources-- the organizations that are actively, actually open. Because those resource lists and the websites that, you know, a group will create, sometimes get outdated quickly. Really quickly.

Nadira also pointed to effective casework as essential to linking people to resources:

N: I believe there are good resources in Clarkston, especially. So many clinics. So many free clinics, so many affordable clinics.

WP: Yeah. So good resources. People don't tend to access them very well. What did you have to do to find doctors for your family?

N: For myself, because I was volunteering in the community, I got the chance to know all these resources. But before I was active in the community, I didn't get any chance to know about this. I believe if you work hand-to-hand with the resettlement agencies—if you give them a clear roadmap to how they can tell the people about your clinic—I think that would be very helpful because I always say,

oh my gosh, why did my case worker never mention that there is a free clinic?
Why my case worker never mentioned that there is something like that?

It's fair to say that there are substantial problems with the process of helping newly arrived refugees gain knowledge of the complex American healthcare delivery system. There are countless individuals in Clarkston with lapsed Medicaid due to misunderstood paperwork, and many more who do not believe that they have access to low-cost healthcare, even when such services exist. This leads to the harmful behaviors demonstrated in Clarkston-area health statistics, such as only visiting the hospital ER for care, rather than accessing a primary care doctor for acute care before a problem becomes too serious.

2. Insurance and Organizational Decision-Making

"I don't even know what the policies are of the other ministries in Clarkston"
– Kevin, a ministry leader

We found that organization leaders frequently doubt their own knowledge of the health insurance system, and that they frequently mis-perceive the behavior of other organizations. One small business owner expressed that "I don't feel comfortable making a decision about insurance without knowing what other people do…I don't know if I'm making a good decision in the market." A ministry director, who is involved with a local association of Christian ministries, expressed that "we never talk about [health insurance] as ministry leaders. Maybe in passing, I've overheard, 'So-and-so this, so-and-so that,' but I don't even know what the policies are of the other ministries in Clarkston." One question on the interview guide asked organization leaders to rate their personal understanding of the health insurance market. None of the 10 participants who led businesses or organizations described themselves as having a good understanding of the market, although several thought that there might be other individuals on their staff who could gather enough information to make a decision.

As implied by Kevin's quote, organization leaders sometimes also misunderstand what other business in their sector are doing. Victor, a local pastor, when asked about what he thought other nonprofits and ministries do for health insurance, responded that "I have no idea what [Organization A] does, but I would assume that they would offer insurance." Organization A was one of the other organizations included in the study, and they do not offer any form of insurance to their employees. Building a more thorough understanding of all the available approaches to offering insurance, as well as the typical decisions of other businesses, seems to be an important component to improving employers' ability to offer insurance. Generally, employers expressed substantial doubt, apprehension, and uncertainty about their business decisions related to insurance, usually leading to inaction.

3. Insurance and Preventative Care

"I look at it as if I get really sick, I've got it. If I'm in an accident, I don't look at it as even, you know, helping me with wellness. I don't look at it as trying to manage my month to month out of pocket expenses. It is there in case I have a heart attack or an accident."
– Kassim, a nonprofit employee

From the perspective of primary healthcare staff or community health practitioners, it is common to view health insurance as a path towards full health and wellness—we might hope that insured individuals view their insurance as a means of accessing preventative care. However, this was not the view of participants in this study, a discrepancy which merits attention

due to its implications for improving the frequency of preventative care visits, and for improving the availability of attractive insurance options in vulnerable populations.

What is the purpose of insurance? Overwhelmingly, participants identified insurance as a source of peace of mind in case of catastrophe, rather than a service which could actually improve their day-to-day health. Most participants adopted an economic view of insurance: weighing its cost vs. the cost of an accident or severe illness. Nadia, a young employee of a local ministry, explained her view in this way: "Especially if you have major things, like my dad had cancer two years ago, and if we hadn't had insurance, that would have hurt us even more. And so, for things like that, I feel like it is worth it, but sometimes, if you're just going in for regular checkups, it would almost be just as cheap to pay out of pocket. Because that's what I'm looking at right now. I'm going to have to get my own soon, and it's like, looking at the prices of insurance through not a workplace...and it's like, 'Is it worth it? I don't know. I think so?'" Another participant, a refugee from North Africa, expressed apprehension about the sustained cost of insurance:

TJ: Since I'm not using it a lot, I'm not going to doctor a lot, sometimes I feel like I'm paying for nothing. Yeah. Because I'm paying $200 every month, but I'm not going to doctor in two, three months. And I already paid $600, but yeah. Yeah. That's how I feel.

WP: Do you think it's valuable to have insurance like that?

TJ: To have insurance, you're kind of on the safety side. Because the most scary thing is emergency conditions. Situations. Not like going to see the doctor regularly. Something that will help with emergencies is the insurance, but without the emergency, I don't see the insurance as very useful because we are not going to doctors every day or every week or every month. We just go as needed.

This perception of insurance as an economic decision, rather than as a potential source of positive behavior change, affects people's willingness to purchase insurance for themselves. Two refugee participants indicated that they believe it is more economical to visit the hospital when sick, and to then go on an installment plan, than to purchase insurance. One described the practice in this way: "I think most people, they go to the hospital. Because it's more cheaper. At the same time they can pay like by months, little by little, instead of paying immediately." Another participant described the practice of installments as a good way for individuals to afford their medical bills, to the exclusion of insurance: "Installments work very well because you pay every month and you really don't feel it like you're spending a lot of money."

Virtually no one said that they frequently visited their doctor for well checks. Hamid described the problem as related to time:

WP: What about when you feel well, do you or people in your family go for well checks with the doctor?

H: Most of the time no, because they don't have time. They just go to work, and can't...

WP: So it takes too much time.

H: The only time they visit the doctor is when they're sick. And most of the refugees, they do the same.

Refugees were slightly more likely than participants born in America to express that they saw value in well checks—several mentioned that they like to have a doctor keep an eye on their bloodwork—but very few participants of any national origin actually go to their doctor for

regular preventative care. This issue is interrelated with almost every other health access issue—it is caused by poor health education, poor health services, and economic poverty.

Conclusion

To an extent, each person's struggle to access the health system is unique. However, when these 31 individual experiences are understood together, it is apparent that many people feel the effects of information problems—mismatches between needs and capacities, and between perceptions and realities. Few actors in the system have bad intentions—healthcare providers generally want to offer excellent care; small businesses and ministries generally want to care for their employees; individuals generally want to be in good health. Nonetheless, when information does not travel efficiently and truthfully between actors, life-threatening gaps may develop. It is the responsibility of conscientious members of the community to remedy these mismatches, in order to create a healthier, more equitable system.

Bibliography

All quotations are from research interviews conducted by Will Payne, May through August 2019.

30021 Zip Code (Clarkston, GA) Detailed Profile. (n.d.). Retrieved from http://www.city-data.com/zips/30021.html

Abbasova, G. (2017). New Collaborative Initiative to Improve Access to Healthcare for Migrant and Refugee Women. *Australian Nursing & Midwifery Journal*, 25(4), 41.

City of Clarkston. (n.d.). Retrieved from http://www.clarkstonga.gov/

Clarkston Community Health Center. (n.d.). Retrieved from https://www.clarkstonhealth.org/home

Clarkston, Georgia Crime. (2019, March). Retrieved from https://www.bestplaces.net/crime/city/georgia/Clarkston

Clarkston, Georgia Jobs. (2019, March). Retrieved from https://www.bestplaces.net/jobs/city/georgia/Clarkston

Grace Village Medical Clinic. (2018, November 08). Retrieved from http://for.ngo/project/grace-village-medical-clinic/?fbclid=IwAR2pACaAzfOdLsMdhgV19ICO0H8rejRItj2wsPZcb77w2WKZLuCVgv4ty30

Health Insurance – Office of Refugee Resettlement. (n.d.). Retrieved from https://www.acf.hhs.gov/orr/health

Kalich, A., Heinemann, L., & Ghahari, S. (2016). A scoping review of immigrant experience of health care access barriers in Canada. *Journal of Immigrant and Minority Health*, 18(3), 697-709.

The Need in Numbers. (2018, May 11). Retrieved from https://www.ethnehealth.org/single-post/2018/05/10/The-Need-in-Numbers

Nicholson, M. (2018). The Role of Faith-Based Organizations in Immigrants' Health and Entrepreneurship. *Center for Migration Studies*. Retrieved from http://cmsny.org/publications/2018smsc-nicholson/

Rodriguez-Lainz, A., Castañeda, X., & Schenker, M. (2014). *Migration and Health: A Research Methods Handbook*. Oakland, California: University of California Press.

Sangaramoorthy, T., & Guevara, E. M. (2017). Immigrant health in rural Maryland: A qualitative study of major barriers to health care access. *Journal of Immigrant and Minority Health*, 19(4), 939-946.

Shaer, M. (2018, July 12). Ellis Island South: Welcome to the most diverse square mile in America. Retrieved from https://www.atlantamagazine.com/great-reads/ellis-island-south-welcome-diverse-square-mile-america/

UDS Mapper. Retrieved from https://www.udsmapper.org/map/app.cfm

United States Census Bureau. 2013-2017 *American Community Survey 5-Year Estimates*.

United States Environmental Protection Agency. (2018). *Environmental Justice Screening and Mapping Tool.*